

FILED OCT 23 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37242**
Registrar's No. **9846**

318 REG. DIST. NO. PRIMARY REG. DIST. NO. **1003**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 9846	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri. b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town or town St. Louis, Mo.) _____		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis,		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1627a Tower Grove, Ave.				e. STREET ADDRESS (If rural, give location) 18 1627a Tower Grove. 21870			
3. NAME OF DECEASED (Type or Print) a. (First) Alice		b. (Middle) Ecton		c. (Last) Hart		4. DATE OF DEATH (Month) (Day) (Year) Oct. 12, 1953.	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH Mar. 25, 1867	
9. AGE (In years last birthday) 86.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 2 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At. Home		11. BIRTHPLACE (City and State or Foreign Country) New Canton, Illinois.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Michael Sigler		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Charles Hart.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Clarence Ecton, Slater, Missouri.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Degeneration ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) same. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4222			
22. I hereby certify that I attended the deceased from June 15, 1950 , to Oct 12, 1953 , that I last saw the deceased alive on Oct 12, 1953 , and that death occurred at 4:25 P.m. , from the causes and on the date stated above.							
23a. SIGNATURE PB Cappelme (Degree or title) _____				23b. ADDRESS 3284 Larchal ave		23c. DATE SIGNED 10-15-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10-13-53		24c. NAME OF CEMETERY OR CREMATORY Elwood Cemetery		24d. LOCATION (City, town, or county) (State) Mexico, Missouri.	
DATE REC'D BY LOCAL REG. OCT 15 1953		REGISTRAR'S SIGNATURE Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Honpa 4700 Washington.			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Fred J. Starnes

Licensed Embalmer No. *4781*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.